Adding humour to the music therapist's tool-kit: reflections on its role in child psychiatry

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Abstract

In this article we reflect on the use of humour in music therapy on a children's psychiatric unit. We review the current literature and, by providing detailed case vignettes, identify four characteristics of humour in music therapy in this context as well as listing the main functions of humour here. We find that humour is a highly subjective experience and that due consideration of the intention behind any use of humour by the music therapist is crucial. Awareness and attunement to one's client are considered vital when dealing with such a powerful multi-faceted phenomenon.

Introduction

Jamie[1] and Nicky are standing facing each other, each holding a violin. Jamie is a seven-year old boy with Attention Deficit Hyperactivity Disorder (ADHD) and Nicky is a music therapist. This is his first time in a music therapy room and he appears a little nervous, yet the novelty of holding the instrument is obviously exciting for him. Jamie begins to pull the bow across the strings quickly. It makes a scraping sound which catches his attention and soon Nicky notices that he seems to be playing four semiquavers in short bursts. Nicky picks up this pattern and initiates a musical dialogue. Jamie then starts to hit his bow off the strings – in an almost col legno fashion - and Nicky echoes this, which makes him laugh. As Jamie's confidence grows, he begins to try different ways of playing his violin, finding the unusual noises very funny. This exploration carries on with much obvious enjoyment until Jamie plays one long scraping down bow. Nicky follows his lead and makes an even more 'disgusting' sound with a long bow exaggerating the follow through with her arm high in the air. Jamie copies her arm movements and seems to delight in making these strange noises; he seems to be especially happy that Nicky is joining him in the 'scraping'. Nicky begins to vary the dynamics of her playing and Jamie responds to this instantly, mimicking the way she moves and the sounds she makes. At this point Jamie and Nicky are both almost bent double with laughter and it is difficult for them to keep their bows on the strings.

This is one example of how a mixture of humour and music can enable a playful non-verbal interaction in music therapy. The strange, unexpected, funny noises

[1] All names and details of the children have been changed to preserve confidentiality.

Jamie began making on the violin suddenly revealed to him that something different could take place and he forgot his anxiety at being in an unknown situation. The playful dialogue led to a shared connection which Nicky felt was crucial in establishing a base on which to build the rest of the session, and indeed therapy. The violin lends itself naturally to absurd or inappropriate sounds and the humour that this elicited held Jamie's interest for a substantial time, which was uncharacteristic.

It is beyond the scope of this dissertation to review the vast literature pertaining to humour: indeed, it seems almost impossible to define categorically the multi-faceted phenomenon that it is. For Kant:

> … humour means the talent of being able to put oneself into a certain mental disposition, in which everything is judged quite differently from the ordinary method (reversed, in fact), and yet in accordance with certain rational principals in such a frame of mind.
>
> (Kant 1951 cited in Simon 1985: 222)

As Freud also argues, humour can afford a much needed periodic release from the obligation to be rational and logical all the time (Freud 1976).

In his extensive writings on the subject, developmental psychologist Paul McGhee (1979) sees the root of humour as incongruity – something inappropriate, bizarre, illogical, absurd or unexpected. For him, it is simpler to set out what humour is *not* rather than what it *is*:

> … humor (like beauty) is something that exists only in our minds and not in the real world. Humor is **not** a characteristic of certain events (such as cartoons, jokes, clowning behaviour etc.), although certain stimulus events are more likely than others to produce the perception of humor. Humor is **not** an emotion, although it may alter our emotional state, and we are more likely to experience it in some emotional states than others. Finally, humor is **not** a

> kind of behaviour (such as laughing or smiling), although specific types of behaviour are characteristically related to the perception of humor.
>
> (McGhee 1979: 6)

One thing which generally seems to be agreed upon by commentators is the fact that humour, along with laughter, is principally a tool for encouraging dialogue of some sort. Indeed, humour can be a catalyst for profound connection in the therapeutic context, as McGhee points out:

> If they thought about it, therapists would probably discover that they had been using humour without being aware of it. Humour is expressed in so many forms and is so ephemeral that a mild jest or ironic remark is quickly passed over as inconsequential and forgotten. Yet its impact may be lasting.
>
> (McGhee & Chapman 1980: 275)

Humour, like music, appears to be a completely subjective experience. Yet, despite the general recognition of the creative capacities inherent in appreciating and initiating humour, there has been a great deal of debate surrounding its use in therapy (Kubie 1971; Poland 1971).

In this article we will be exploring the role of humour in our work as music therapists, focusing in particular on music therapy in child psychiatry. The quote above and the preceding clinical example indicate that humour has a part to play in music therapy and our aim is not only to examine *when* humour is used in music therapy in child psychiatry but also to look at what characterises its use. To begin with we will briefly review the current literature regarding humour in music therapy. Next, by concentrating on two further case vignettes - one where humour was used to encourage dialogue and one where humour was used to obstruct interaction - we will draw out certain characteristics of humour in music therapy. Finally, we will summarise the main uses of humour in this setting[2].

[2] Some of this work was originally undertaken by Nicky Haire as part of her dissertation for her MA in Music Therapy at Anglia Ruskin University (Haire 2008).

Humour in music therapy

The potential inherent in music to arouse certain emotions is well documented (Meyer 1956; Sloboda 1991; Juslin & Sloboda 2001) and yet, while humorous music has benefited from a number of studies (e.g. Huron 2004; Smith 1994; Walton 1993), very little has been written specifically about humour in music therapy. Nevertheless, as the music therapist Dorit Amir states in her research study *Musical Humour in Improvisational Music Therapy,* '…humour is an integral and essential aspect of therapy and therefore, like any other aspect of the therapeutic work, it needs to be researched' (Amir 2005: 3).

Winnicott states:

> … this sense of humour is evidence of freedom, the opposite of the rigidity of the defences that characterises willingness. A sense of humour is the ally of the therapist, who gets from it a feeling of confidence and a sense of having elbow room for manoeuvring.
>
> (Winnicott 1971: 32 cited in McGhee & Chapman 1980: 274)

Amir (2005) feels that music as a medium is unique in encouraging therapists and clients to use their imagination, feel freer and be spontaneous and creative. It would seem that spontaneous musical improvisations and humour have in common the qualities mentioned by Winnicott above.

In his paper entitled 'An Age-Based Comparison of Humour in Selected Musical Compositions', Smith (1994) attempts to explore some of the reasons why certain music is perceived as humorous. He asserts that in addition to those pieces which employ humorous compositional techniques - for example, unusual sounds or unexpected harmonic progressions - one also has to consider the visual aspect, which can increase the humorous response dramatically.

Inspired by Gabrielsson & Juslin, Bunt & Pavlicevic (1996, cited in Juslin & Sloboda 2001) carried out a study of the links between the performer's expressive intention and the listener's experience. They concentrated on improvisations rather than pre-composed pieces of music in order to eliminate the 'familiarity aspect' of known pieces. This test was carried out live by two groups comprising music therapy teachers, music therapy students and music therapy researchers. Each 'performer' chose a mood/emotion - happy, sad, angry, fearful or tender - from which to improvise; after two minutes, listeners were asked to identify the emotion.

Overall, the performers were able to communicate accurately the emotion intended and Bunt & Pavlicevic categorised the main criteria used by the listeners when decoding the emotions. In the case of 'happy', the following musical and expressive criteria were identified:

- Tempo and rhythm: fast, flowing tempi; lively, skipping dotted rhythms; firm pulse
- Pitch and melody: high pitches, rising melodies
- Tonality and harmony: major tonality, clear structured harmony
- Timbre, texture and style: bright textures and timbre, much staccato
- Loudness level: no major shifts, mainly middle ground
- Phrasing and structure: clear, predictable, many short 'flourishes'
- Non verbal communication: smiling, free body movements, foot tapping, bouncing, clapping, upright posture with no apparent tension, a 'twinkle in the eye'
- Other: feeling of abandonment, much communication of high levels of energy, meeting cultural expectation of feeling happy

(Bunt & Pavlicevic1996, cited in Juslin & Sloboda 2001: 190)

As is clear from the criteria listed above and as Amir (2005) notes, the phenomenon of musical humour is multi-dimensional. Stern (1977), when discussing very early parent/infant interactions, uses the term 'cross modal' to describe this multi-dimensional way of communicating. As can be seen from the above list, when determining expressive intent, the visual aspect - for example facial expressions and body language - seems to be as important as the music.

Huron (2004) identifies the following musical devices used by the composer Peter Shickele (PDQ Bach) for comic effect: 'incongruous sounds, mixed genres, drifting tonality, metric disruptions, implausible delays, excessive repetition, incompetence cues, incongruous quotation and misquotation' (Huron 2004: 703). He goes on to point out that:

> Laughter appears to be linked to the greatest or most marked violations of expectation. Laughter is always facilitated by a context that appears to be overtly one of playfulness and parody.
>
> (Huron 2004: 703)

Similarly, Amir (2005) lists the following specific musical features present in humorous exchanges in music therapy:

> … dynamic interruptions, eccentric/unusual rhythmic development, unexpected notes, unprepared dissonances, awkward intervals, inexplicable harmonizations and accelerando/glissandi
>
> (Amir 2005: 6)

Drawing on Lister's research (1994, cited in Amir 2005), Amir (2005) terms this 'pure' kind of musical humour 'absolute humour', to differentiate it from the extra-musical feelings or memories provoked by it which she terms 'referential humour':

> … that is, the extra musical connotations and associations which make the music perceived as humorous….For example, accelerando might be perceived as humorous because of the association or image of a competition: "We are running; let's see who gets there first."
>
> (Amir 2005: 10)

Amir (2005) concludes that, in addition to the main musical gestures of 'exaggeration, clumsiness and incongruity…' which she considers humorous in improvisational music therapy, other humorous experiences in this setting include 'musical jokes; the use of parody; caricature, and comedy, imitation; non musical sounds; and certain instruments' (Amir 2005: 17).

So, musical improvisation in music therapy - like humour - seems to be a multi-dimensional experience combining musical features, verbal communication and physical gestures. Therefore, the personal characteristics and preferences of the therapist, along with the particular client group they are working with, will have an influence on the presence of humour (Freud 1976). And as the research of music therapists Brynjulf Stige (2003) and Even Ruud (1998) makes clear, it is impossible to separate sounds or the significance of those sounds from cultural experience. This is reinforced by Amir, who states that much of the success in using humour as a tool depends on factors such as 'being part of the same culture…having a shared past and sharing the same musical knowledge' (Amir 2005: 10-11). Having the same musical knowledge goes some way towards establishing a familiar basis on which humour can be used and understood by both client and therapist. Indeed the numerous ways in which humour and music can be employed and interpreted serve to reinforce the fact that care is needed by music therapists when using both. As Burleigh and Hardy state:

> It cannot be assumed that everyone will find the same situation hysterically funny…. An awareness of when it is inappropriate is essential, as someone's sense of humour is personally honed and influenced by social and cultural factors.

(Burleigh and Hardy 1997: 446)

While working on song writing with young patients on a hospital ward for children with cancer, Aasgaard states:

> Humour is a prominent feature of many of the songs… The song creators express humour through lyrics, music and through particular ways of performing the song.
>
> (Aasgaard 2005: 86)

He notes that the children used humour in a variety of ways, showing their creative initiative when faced with often tragic circumstances. Firstly, he cites the use of ironic humour where serious subject matter was presented in an innocent, familiar way, using nursery rhymes for example. He gives this example based on the familiar nursery rhyme *Baa Baa Black Sheep*:

> Ba ba blood corpuscules
> You are far too few!
> Yes, yes, we'll increase,
> But smile and laugh must you!
>
> (Aasgaard 2002: 86)

A second type of humour is seen in the 'coarse lyrics' some children used which served as a way of venting their anger and frustration in an 'acceptable' manner. And finally Aasgaard finds that other songs 'open the door to a fantastic and playful world having few or no 'real life' references' (Aasgaard 2005: 87). In these songs, children used made-up words combined with 'merry' melodies.

> Humour, actually a bag with many different expressive tricks, is more prominent in these 19 songs than depressive, scornful or openly angry voices, even when the dark sides of cancer and hospitalisation are dealt with. This tendency can also be observed in the music. Even when the lyrical

> theme can be understood as rather gloomy, the preferred musical style is usually light and gay.
>
> (Aasgaard 2005: 87)

Like Huron (2004), music therapist Ulla Holck (2002) also finds, when working with children with communication disorders, that musical humour is closely linked to expectations. The concept of learned expectation is not a new one (Meyer 1956) and, according to Holck, in music therapy a response-evoking technique is dependent on the fact that a child has developed a musical expectation within a musical structure. When the expectation is not fulfilled - for example, when a steady drum beat is interrupted - most children (but as she makes clear, not all) will recognise the 'surprise' element of this, smile and be drawn into a playful interaction. A playful approach is often seen as one of the best ways of beginning and sustaining a therapeutic interaction with a child (McGhee 1979).

In therapy, one of the most important aims is to establish and sustain a connection. This, according to McGhee (1979), is especially true with children. However, McGhee also makes clear that, along with all the other tools in the therapist's tool kit, the effectiveness of humour depends on how skilfully it is used. This is as true in the music therapy setting as in any other therapeutic context.

Clinical examples

We will now focus on two specific instances in individual and group settings in a child and family psychiatric unit where certain characteristics of humour were in evidence. The unit provides day and inpatient assessment and treatment resources for up to eight children (0 -12 years old) and their families. All names and identifiable details have been changed.

Billy

The following example illustrates the use of musical imitation leading to playful humorous interaction. This is particularly important because Billy usually has difficulties relating to adults non-defiantly.

Billy is a very anxious seven-year-old with challenging behaviour and a history of school refusal. He has great difficulty in group settings where he tends to be very disruptive and constantly incites chaos: however, Nicky found him engaged and interactive on a one-to-one basis albeit noticeably nervous about playing the instruments correctly. Although Billy came from a musical family and had previously had some music lessons, he had not had music therapy in the past. Nicky saw Billy for four individual sessions, one joint session with him and his mother, and he took part in six group sessions with the other children on the unit. The main therapeutic aims with Billy in individual sessions were to address his disruptive challenging behaviour, to deal with his anxiety and to find a way of encouraging him to relate to adults - specifically his mother - in a less defiant and more positive way. The interaction described takes place in session one:

> *Billy and Nicky are both standing facing each other in front of two small chairs and Nicky has chosen the reed horns for both of them to play. Billy takes the reed horn Nicky offers him and then waits expectantly so Nicky blows her horn first. Billy immediately imitates this and almost instantaneously they fall into a kind of natural rhythm of "tooting" back and forth. As this rhythm becomes established, Nicky begins to walk around the chairs to emphasise the musical structure. Billy follows and so they both step rhythmically in a kind of figure of eight round the chairs. Watching this particular passage of the interaction back on video, it almost looks like a dance that has been planned beforehand: there is not only musical imitation happening - with both of them making 'wah wah wah' laughing-type sounds into their horns - but also physical interaction.*

At this point Nicky is aware that Billy might be getting a little over-animated and decides to sit down on one of the chairs to moderate his level of excitement. When she sits down he also stops moving but does not sit: instead he comes and stands in front of Nicky, meeting her horn with his at the same height. He blows loudly through his horn into Nicky's and laughs. Nicky picks up on this humour by making 'funny' gestures with her arms as she continues to blow her horn. They begin to imitate each other as they had been earlier using their arms and body movement: it is difficult to tell who is leading and who is following, and Nicky remembers feeling at the time that it was a very equal exchange. In terms of Stern's (1977) concept of affect attunement, Nicky's role here is comparable to that of a primary caregiver: although she is matching and holding Billy's playing and feeling and reflecting back his, she is also inserting new ideas which he is then able to copy and respond to.

The dialogue continues like this for another two minutes, one leading and then the other trying something new which is picked up on and elaborated. As they begin to cross in and out of matching and not matching each other, and the pace of the exchange decreases, Nicky initiates an over-exaggerated 'one, two, three, end!' and Billy comes with her. Even on the very last note Billy imitates her hand signal accurately and they both laugh at this.

The music therapy group

Thus far this article has been concerned with how humour can enable or encourage dialogue between people and how this can be of use in the therapeutic context. In this next example we highlight how humour can be used as a mask.

This particular group consists of seven people. Dan is a six year old boy with a diagnosis of autism spectrum disorder, Ender is a ten year old boy with attachment issues and a tendency to 'act the clown', Frank is a seven year old

boy with a learning disability and diagnosis of autism spectrum disorder and Georges is a seven year old boy with a pending diagnosis of ADHD. In addition to these four children, Amelia is leading the group as the music therapist, with Nicky and a psychiatric nurse working as co-therapists.

> *About fifteen minutes into the group session, Amelia initiates a conducting game. Here, each member of the group is given a turn as the conductor and the others have to follow musically whatever the conductor does. Amelia is encouraging Frank to have the confidence to take control of the group. However Frank refuses to take the 'baton' and begins to laugh somewhat nervously, so in an effort to allow him a sense of leadership Amelia picks up on the low pitched laugh he is making. At first she imitates him and then turns the laugh into a musical phrase. The group is quickly united in singing this phrase and as Frank realises what is happening, his laughter begins to increase, seeming more and more forced.*
>
> *Initially, he appears to be playing to the group and enjoying his role of leader but then he becomes fixated with another member of the group (Ender) and is quickly stuck in imitating Ender's movements and facial expressions. At first it seems as though humour is uniting Frank and Ender: however, Frank is not making eye contact or actually engaging with Ender and, as the behaviour continues, it becomes apparent that Frank is using this laughter as some sort of mask. Despite constant and varied attempts to re engage Frank, it is not until the very end of the group session, when all the other members have left that he is able to stop laughing and come out of his apparent humorous daze.*

This experience was profoundly affecting. The degree to which Frank kept his 'mask' on was actually quite frightening. Perhaps this could be interpreted as a countertransferential reaction to what Frank was feeling himself. Terrified at being asked to lead the group, and even more frightened when his vocal contribution was picked up and echoed by the group, he seemed to retreat behind a clown-like mask in an effort to reinforce his own status as a

stereotypical court jester figure – thus eschewing all chance of being taken seriously and the responsibility this could entail. In McGhee's terms (1980), Frank's manic kind of laughter did indeed seem very like a defence, 'conscripted' by him whilst under 'attack'.

Different characteristics of humour

From the case examples presented in this article, it would appear that humour can be characterised in a number of different ways. ***Imitation*** and ***repetition*** were apparent in all three examples and central to the humorous nature of the exchanges. In all three examples the therapist initially imitates the client but the client later also imitates the therapist. Repetition occurs but is then elaborated upon and varied. These variations often result through over-***exaggeration***, a key characteristic in humorous dialogue. At other times the variations are not only exaggerated but turned into something unexpected or incongruous which, as mentioned earlier, is central to humorous effect. Indeed ***incongruity*** could be seen as a fourth characteristic of the use of humour.

We also found that we could categorise a number of different uses of humour in music therapy. For example:

Humour as an 'ice breaker': it is often the case that some form of humour enables children to forget that they are in 'a therapy room' and feel freer and more able to play (as can be seen from the first example at the beginning of this article with Nicky and Jamie).

Humour as diversion/diffusion: humour can be very useful in distracting children who are becoming aggressive or challenging in their behaviour. 'Comedy' instruments (e.g.: swannee whistle, duck whistle, train whistle, ukeleles, kazoos and boom whackers) being instantaneous in their effect, are

valuable devices for diffusing potentially difficult situations and also for extending the concentration of the child. When working with Billy, Nicky found that the use of humour was an important tool to help him relate to adults in a positive rather than a defiant way.

Humour as an 'equaliser': humour is often talked about as being 'a leveller' in social situations and this seems pertinent especially when clients are perhaps slightly embarrassed and uneasy about engaging using the musical instruments thus needing some encouragement in overcoming their awkwardness. The exchanges that Nicky had with both Jamie and Billy also felt very 'equal' giving the child and the therapist similar roles in their musical exchange.

Humour as encouragement of socialising: 'Rather than sharing humour, it is the sharing of the social situation which is important*'* (McGhee & Chapman 1980: 164). The structure of the music and the use of humour to engage children are crucial in allowing children to be part of a group experience. Even though the group used earlier as an example was concerned with humour being used as a mask, the uniting qualities of humour and music are also very much in evidence here.

Humour in addressing issues of control: As Oldfield (2006) makes clear, the issue of control appears to be central in child (and family) psychiatry. The music provides a structure, a means of communicating and a motivation for the child. The therapist can use humorous gestures combined with musical games both to observe and to allow different people to experience being in control, or being controlled, in a non-challenging way. When Amelia imitated Frank in the group example, she was attempting to give him musical control over the group and allow him to experience this leading role positively. As Amir states: 'the language of humour is indirect and therefore allows exposure of weakness, difficulties and pain in a non-threatening way' (Amir 2005: 18).

Humour to instil hope: The word 'joy' is not one which is often associated with the word 'therapy'. However, the notion that humour, through its creative and spontaneous characteristics, can change things which otherwise seem 'fixed' engenders feelings of hope vital to the therapeutic process. Sharing a joyful moment in the therapy room can be essential. Aasgard (2005) makes this very clear in the work with children with cancer mentioned earlier.

Conclusion

In this article we have suggested that some of the main characteristics of humour in music therapy with children in a psychiatric setting could be described as **repetition, imitation, exaggeration** and **incongruity**: three examples have been given where these qualities are in evidence. This largely corresponds with Amir's list of principal musical characteristics: 'exaggeration, incongruity and clumsiness' (Amir 2005: 17), and also relates to McGhee's (1979) concept that incongruity is central to humorous experience.

We have also found that humour can be used in a number of different ways: as an **ice-breaker**, a **diversion**, an **equaliser**, a means of **socialising**, to address **issues of control** and to **instil hope**.

In addition, it has been noted that the use of humour depends largely on the personal characteristics of the therapist, the individual needs of the client and a shared cultural understanding. What seems particularly important in the therapeutic context is the intention behind the use of humour: as McGhee makes clear, the intention of the therapist may be very different from that of the client. Often the child is not concerned about or is unaware of the therapeutic process: for him or her, a moment of humour can be but 'a moment of playful amusement' (McGhee & Chapman 1980: 268). We have certainly found that clients tend to use humour primarily for their own amusement (whilst acting the clown, for

example) and it is more commonly used as an obstruction, defence or attention-seeking device in group settings (Haire 2008).

Nevertheless, humour principally encourages dialogue and can offer a way of enticing a child into a setting or situation which for the child can seem unknown and needless (McGhee & Chapman 1980). It can also be used as a positive way of modelling interaction in this setting. However, as highlighted by the case vignettes, humour can be immensely powerful and awareness with regard to the use of humour in any therapeutic context is crucial. Thus humour deserves proper consideration as a phenomenon which can be skilfully employed to further therapeutic aims.

We have shown that the therapist must be aware of its use as an obstruction to interaction; temptations to ignore the 'real' problem or use it as a 'quick fix' solution in therapy must be addressed. Children - who tend to be more spontaneous and usually less restrained when displaying their feelings than adults – do on occasion use a kind of humour as something to hide behind. Nevertheless, whether it occurs spontaneously or intentionally, it provides rich therapeutic material.

To return to the title, this article demonstrates that humour is a useful addition to the music therapist's 'tool-kit' in child psychiatry, but that it should be used with care and consideration. Humour could be considered, as Alvarez states when discussing children and play, as 'not necessarily a denial of a past reality or a current pain, but a tentative question about the possibility of a new version of the present and even a new view of the future' (Alvarez 1992, cited in Lemma 2000: 88).

Coda

There are five minutes left of the session. Jamie sits restlessly in his small chair waiting for Nicky to bring the bongo drums across. She sits down opposite Jamie and puts the drums across their knees, creating a link between them. Nicky begins to sing 'goodbye' to Jamie while hitting the bongo drums rhythmically. Immediately Jamie begins to imitate Nicky in a silly fashion, over-exaggerating her gestures on the drum and cheekily disagreeing with everything she sings: 'No, I won't see you next week, ha ha ha ha ha!' he squeals. Nicky realises that he is 'making fun' of the song, and of Nicky singing it: could it be that he is trying to avoid having to say goodbye? Having been relatively restrained and well-behaved up until this point, he seems to be using humour as a means of covering up the fact that he does not actually want to leave the session.

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